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Mr. Chairman and members of the Committee, I am Bill Novelli, Executive Director and CEO of AARP. On behalf of the organization and our 35 million members, I want to thank you for convening this hearing and for continuing your efforts to consider the best approaches for adding a much needed prescription drug benefit to the Medicare program.

As AARP looks toward building retirement security for today's older Americans and the baby boom population, we believe no person is economically secure without adequate medical insurance. The structure of retirement security is no longer simply the "three-legged stool" of Social Security, private pensions, and personal savings, but rather four pillars consisting of: Social Security, pensions and savings, earnings, and, importantly, stable, affordable and adequate health insurance.

Consequently, now more than ever, Americans of all ages are looking to Medicare's guarantee of affordable health care coverage as part of the foundation of their retirement planning. But there is a serious gap in Medicare's protection – the absence of reliable prescription drug coverage.

While modern medicine increasingly relies on drug therapies, the benefits of these prescription drugs elude more Medicare beneficiaries every day. Drug costs continue to rise unabated. Employer-based retiree health coverage is eroding. Managed care plans in Medicare have scaled back their drug benefits. The cost of private coverage is increasingly unaffordable. State programs provide only a limited safety net. Therefore, the need for a Medicare drug benefit will only continue to grow.

Given the prominence of drug therapies in the practice of medicine, if Medicare were being designed today – rather than in 1965 – not including a prescription drug benefit

would be as absurd as not covering doctor visits or hospital stays. That is one of the reasons why ensuring that prescription drug coverage is included in Medicare's defined benefit package is AARP's number one legislative priority this year. Our members and their families need and expect a meaningful benefit that is affordable and available to all beneficiaries. They expect us to be their champion on this issue and we will be.

We are pleased to be here today to discuss the President's budget proposal for prescription drugs and Medicare reform and to share with you some initial findings of what our members need in terms of Medicare prescription drug coverage.

The President's Budget Request & Proposal to Modernize Medicare

The President's FY 2003 budget request includes $190 billion over the next ten years for prescription drugs and other changes. AARP is pleased that the President continues to make Medicare prescription drug coverage a priority for his Administration and has indicated his willingness to work with the Congress on this issue.

The Administration's budget does not provide details on how it would address the need for an affordable prescription drug benefit, but the dollar amount proposed in the President's budget is insufficient for an affordable and meaningful drug benefit for all Medicare beneficiaries. A brief review of the various components of the President's Medicare proposal highlights AARP's concerns.

Low-Income Proposal - Out of the $190 billion in the President's budget, $77 billion in Medicare dollars are earmarked for low-income drug coverage. The budget proposes an enhanced federal match to enable states to cover drug costs for Medicare beneficiaries between 100 and 150 percent of poverty.

While we must provide additional financial assistance for low-income individuals, low-income assistance is not a substitute for a prescription drug benefit in Medicare. Also, proposals to provide additional financial assistance for low-income individuals should be

clear as to how the proposed targeted low-income assistance would be used (e.g., in Medicaid expansions or state pharmacy assistance programs), how this effort would improve the current patchwork of drug assistance available, and how many people would actually be helped. For instance, 17 states and the District of Columbia have assistance programs up to 100 percent of poverty. The Administration's budget would "allow states to expand drug coverage to Medicare beneficiaries up to 100 percent of poverty" but does not provide any additional assistance for states to do so. It leaves open the question of whether states that could not raise their Medicaid thresholds would be eligible for the new enhanced federal match between 100 to 150 percent of poverty.

The Administration's proposal does not include a maintenance-of-effort requirement to prevent "dollar trading" by the states that already have higher thresholds. Those states that already cover beneficiaries up to 150 percent of poverty might substitute federal dollars for their current commitment and not expand their state efforts. Without safeguards, the end result for $77 billion in federal funding could be little or no extension of prescription drug protections for needy seniors.

Discount Card - The President's budget includes the Administration's proposal to implement a Medicare drug discount card that would give beneficiaries immediate access to drug discounts and other pharmacy services. Medicare would endorse cards that meet criteria for customer service and other key functions. Card sponsors would negotiate discounts with manufacturers and retailers, thus lowering drug prices for beneficiaries. The proposal has now been released in the *Federal Register* as a proposed rule.

AARP is encouraged that – unlike current industry card proposals – the President's proposed discount card is designed to establish the drug card program as a building block for a full Medicare drug benefit. We emphasize, however, that neither the Administration's discount card or the current industry cards are a substitute for a real drug benefit.

We also believe that while the actual discounts would be relatively modest, the President's discount card program would provide at least some help to beneficiaries in buying the drugs they need. It could provide important safeguards to improve the appropriate use of prescription drugs, and this could help avoid unnecessary health care costs due to drug interactions, mis-medications, or poor compliance. It also, importantly, would help the federal government learn valuable lessons about the pharmacy benefit managers (PBMs) that run discount card programs and are included as the delivery system in virtually every drug benefit proposal before Congress. As a result, it will help the Medicare program become more familiar with how PBMs and drug benefit programs work.

AARP plans to work with the Administration as it continues to refine the drug card proposal. There are several issues that we will try to clarify and some consumer protections we will try to add, including: defining what constitutes a "substantial" discount, obtaining firm details on how manufacturer discounts will be disclosed and passed on to consumers, assuring that consumers can compare drug card discount rates to actual retail prices, and making sure drug cards help consumers get generic drugs whenever they are medically appropriate and the least costly option.

Medicare Modernizations – The President's budget includes approximately $116 billion for Medicare program "modernizations." Included in the total is funding for enhanced Medicare+Choice payments, some preventive services, and prescription drug coverage. The President's budget also includes a new solvency trigger for Medicare spending. We are concerned that the limited amount of funding in the Administration budget for both drug coverage and other program changes is insufficient to add a meaningful drug benefit and strengthen the program for current and future beneficiaries.

AARP supports efforts to modernize the Medicare program. Clearly, the creation of a prescription drug benefit that is available in all Medicare options is the most significant improvement, but other changes are also important and would serve beneficiaries and the program well. For instance, many private health insurance plans offer a cap on out-of-

pocket expenses, yet there is no such limit in the Medicare program. Creating an out-of-pocket cap for services currently covered by Medicare Parts A and B would not only bring Medicare more in line with what individuals under the age of 65 currently have, but would also make the program more affordable for beneficiaries.

AARP also remains open to the possibility of combining the Part A and B deductible, provided it is structured to be affordable and does not produce beneficiary "sticker shock." Since most beneficiaries meet the annual $100 Part B deductible but significantly less meet the Part A hospital deductible, a combined and increased deductible will affect the majority of beneficiaries. We are opposed, however, to merging the Part A and B Trust Funds. The new solvency measure included in the President's budget appears to suggest that Medicare should be financed wholly from its Trust Funds. That is, its financing should come predominantly, if not exclusively, from payroll taxes and beneficiary contributions, with little or no contribution from general revenues. This would represent a radical shift in funding for the Medicare program. The impact of such a shift would be to significantly increase beneficiaries' costs for Medicare, reduce provider payments, or a combination of both.

In sum, while the President is to be commended for making Medicare prescription drug coverage a priority, the budget number is insufficient. AARP believes that it would be a mistake to let a low number drive the design of a prescription drug benefit and Medicare reforms, rather than letting the right policy guide budget decisions.

What AARP Members Need

High need, high drug prices, and inadequate insurance coverage pose serious problems for today's Medicare beneficiaries. A chronic health problem necessitating new and expensive prescription drugs can quickly deplete a retiree's financial resources. Even a beneficiary who has planned well for his or her retirement may not be prepared for drug bills that exceed several hundred dollars a month. Further, it is important to note that support for making a prescription drug benefit part of Medicare is overwhelmingly high

for all of our members. Americans of all ages recognize the value of prescription drug coverage. In recent polling conducted for AARP, eight in ten Americans age 45 and over favor making prescription drug coverage part of Medicare.

The majority of Medicare beneficiaries – not just those with low incomes – need drug coverage. Because of Medicare's current lack of prescription drug coverage, many beneficiaries must pay for all or some of their prescription drugs out-of-pocket. Although 65 percent of Medicare beneficiaries have some type of coverage for prescription drugs, this figure can be very misleading.

The principal sources of coverage that offer a prescription drug benefit – employer-based retiree coverage, private supplemental coverage, or Medicare HMOs – are often inadequate, limited, expensive, and unstable. Moreover, many Medicare beneficiaries do not have continuous prescription drug coverage. A Commonwealth study released last month reported that nearly 42 percent of beneficiaries lacked drug coverage at some point in 1998. More recently, a new study published by *Health Affairs* reports that nearly 40 percent of Medicare beneficiaries had no drug coverage in the fall of 1999. It is also important to understand that those Medicare beneficiaries without coverage pay top dollar for their prescriptions because they do not benefit from discounts negotiated by third party payers. Most of those currently covered by insurance, including most workers, benefit from such discounted prices.

Let me give you some illustrative examples:

- A retired couple that earns only about $18,000 a year -- or about 150 percent of poverty – still is above the threshold for Medicaid in most states and most state and private pharmacy assistance programs. Medigap policies that include prescription drug coverage are unaffordable based on their income, there are no Medicare+Choice plans available in their area, and they do not have access to retiree health benefits through a former employer.

- A retired couple that has significantly saved for retirement and earns $30,000 a year. They have prescription drug coverage through a Medicare HMO. This year they learn, however, that their HMO plans to terminate its contract with Medicare, effective December 31. There are no other Medicare HMOs in their area, and while they can afford supplemental insurance and are guaranteed access to certain Medigap plans (A,B,C, and F), none of these plans include drug coverage.

- A 75-year old widow is enrolled in a Medicare HMO that offers drug coverage. She currently has prescriptions for a cholesterol-lowering medication at $97.51 a month and an allergy medication at $46.94 a month. While initially her drug coverage was quite generous, this year her drug benefit is capped at $300 a year. This means she basically has no drug coverage for three-quarters of the year.

Dependable Drug Coverage - Our members seek ***dependable*** drug coverage. Current prescription drug coverage options are not reliable. For example, beneficiaries who obtain prescription drug coverage from their former employer are finding that coverage to be unstable. Retiree health benefits that include prescription drug coverage are becoming more scarce. While an estimated 40 percent of employers with 500 or more employees offered retiree medical coverage in 1993, only 23 percent did so in 2001. Of those employers who offered retiree medical benefits, 21 percent do not offer drug coverage to Medicare eligible retirees.

In addition, beneficiaries who have drug coverage through Medicare HMOs cannot depend on having this coverage from year to year, as plans can change benefits on an annual basis or even terminate participation in Medicare. For example, this year many beneficiaries in Medicare+Choice plans are living through abrupt changes in their prescription drug coverage that they did not foresee when they enrolled. Some of the most visible of these changes include:

- Increasing premiums. Over the past few years, more and more Medicare+Choice plans have been charging premiums for their coverage, and those premiums are escalating. For example, between 2001 and 2002, the percent of Medicare HMO enrollees with zero premiums declined from 47 to 39 percent. This year, nearly one-third of Medicare HMO enrollees (32 percent) will have basic premiums over $50 compared to 14 percent in 2001.

- Higher cost-sharing – Unlike the 1990s, all Medicare HMOs that offer prescription drugs are charging copays for prescription drugs and the average beneficiary copay has increased significantly.

- Decreasing benefit – More plans are lowering the annual cap on the typical Medicare+Choice drug benefit. While in 1999 10.6 percent of Medicare HMOs had an annual cap of $500 or less on their drug benefit, 20.6 percent of plans had a $500 cap in 2000.

- Loss of benefit – Over the last few years several Medicare+Choice plans have dropped their prescription drug benefit entirely. While 88 percent of Medicare HMOs offered some drug coverage in 1999, that number declined to 63 percent in 2001. Although Medicare+Choice has provided beneficiaries with an opportunity for drug coverage, the volatility of the Medicare+Choice market has made that coverage unpredictable and unstable from year to year.

Affordable Drug Coverage – Older Americans also need ***affordable*** drug coverage. In establishing a voluntary drug benefit, the benefit needs to be affordable to assure enough participation to avoid the dangers of risk selection. The government contribution will need to be sufficient to yield a beneficiary premium that is affordable and a benefit design that is attractive to the majority of beneficiaries. If the benefit is not set at an affordable level, only those beneficiaries who have high risk will want to purchase it. This will mean that the only ones in the risk pool will be those with high drug costs and the benefit costs will escalate rapidly into what is often referred to as an "insurance death

spiral." This is not simply a matter of what beneficiaries would like to pay, it is an issue of how to assure fiscal viability of the risk pool. Medicare Part B is a model in this regard.

The Part B benefit is voluntary on its face, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation. Actuarial work done for AARP last year by the William M. Mercer Company, and which we shared with the Committee, identified that the key to success for a Medicare prescription drug benefit is to:

- ✓ develop a benefit design that will encourage participation by a broad range of beneficiaries in order to spread risk;
- ✓ ensure clear and concise communications to improve participation
- ✓ balance the breadth of coverage and beneficiary premium;
- ✓ implement cost-containment techniques; and
- ✓ limit the enrollment period.

We have asked our members and the general public what kind of benefit package would generate this kind of high level of participation in the benefit, and we have learned the following thus far:

- Beneficiaries will generally perform what we call the "kitchen table test" in determining whether they would purchase a new voluntary drug benefit. That is, they will likely calculate their current prescription drug costs, their current Medicare premium ($54 a month in 2002 and rising to $114 in 2010), any drug coverage they might currently have, and their current financial situation, in determining whether a proposed benefit is a real value for them.

- Medicare beneficiaries are willing to pay their fair share for a solid prescription drug benefit, but the premium and coinsurance must be reasonable. We know, for instance, that beneficiaries would not be likely to enroll in a prescription drug plan with a premium of $50 a month.

- While the amount of the beneficiary premium drives the equation, our members also look at the program design features in combination with one another. This means it is difficult to simply assess a single component of a package. For instance, some beneficiaries might look more favorably on a higher level of coinsurance if the premium was lower, or vice versa. In a recent poll conducted for AARP of 885 individuals age 45 and over, only one-third of those 65 and over would be likely to participate in a prescription drug plan that included: a $35 monthly premium, 50% coinsurance, a $200 annual deductible, and a $4,000 stop loss.

- Most Medicare beneficiaries are concerned about the unpredictability of health care costs and want to know what they will be expected to pay out-of-pocket. This makes real catastrophic stop-loss protection that limits out-of-pocket costs an important component of any package. We know from past experience that a $6,000 catastrophic stop-loss is viewed by beneficiaries as too high, and even a $4,000 cap is not viewed as providing much benefit protection.

We will continue to seek the views of AARP members and future members on specific design packages and we would be happy to work with the Committee as proposals are developed.

A Medicare Drug Benefit Requires Adequate Funding

AARP members have told us – through public opinion polling, letters, e-mails and prescription drug events across the country – that they want Congress to implement a Medicare prescription drug benefit. AARP knows that to craft the kind of prescription

drug coverage that beneficiaries will find affordable and reliable – and will thus voluntarily choose to sign up for – will require a sizable commitment of federal dollars.

We recognize that budget constraints are greater than last year. But while the budget situation changes from year to year, the situation facing millions of older and disabled persons who cannot afford the drugs they need continues to worsen, and constitutes a health care and financial emergency that cannot continue to be ignored.

We fully agree with the sentiment voiced by members of this committee that solid public policy should drive the funding of a prescription drug benefit, not the reverse. That is why we have asked Congress to renew its commitment from last year, adjusted for inflation and another year of coverage, to earmark $350 billion for prescription drugs and reforms that strengthen the program. However, we believe that even this level of funding is inadequate to pay for what our members would consider an adequate and affordable benefit. Therefore, in addition to the $350 billion set-aside for prescription drugs and program reform, we have recommended that Congress create a reserve fund of about $400 billion, or an amount roughly equal to the amount of the 10-year surplus in the Medicare Hospital Insurance (HI) Trust Fund. A majority of the respondents to our recent poll favored borrowing from the Medicare surplus to pay for a prescription drug benefit. Our poll indicates that the combination of the $350 billion commitment based on last year, plus the roughly $400 billion reserve fund, will give the Congress the flexibility it needs to craft a prescription drug benefit that beneficiaries will perceive as having real value.

We do not, at this point, have an estimate of what an adequate drug benefit will cost. We know the plans costing $300 billion offered last year did not find public acceptance. We believe Congress and this Committee should focus on the design of a sustainable benefit that makes sense to beneficiaries and remain flexible as to the projected cost. Through the budget set-aside and reserve fund, the Congressional authorizing committees will be able to develop a drug benefit that beneficiaries need and want. We pledge our assistance in this effort.

Further, since the bulk of funding for a Medicare prescription drug benefit will occur in the last years of the budget window, we view the reserve fund as giving Medicare "first claim" on the unified budget surplus attributable to the surplus in the Medicare Trust Fund forecasted by the Congressional Budget Office.

AARP members fully recognize that there are added priorities and greater budget constraints since last year. However, disease and pain have not disappeared with the surplus and putting off creation of a drug benefit is not going to get any easier. Therefore, we are calling on Congress to act now. This is a priority for our members and the cost of inaction will be great.

In addition to our prescription drug recommendation, we also have said that it would be irresponsible to use Medicare or Social Security surplus dollars to increase provider payments without first ensuring that older Americans get the prescription drug coverage they need. Our members would not understand why Congress could find money to help providers but not to meet their increasing prescription drug needs. We, therefore, would strongly oppose funding for a "give-backs" package prior to agreement on a Medicare improvement package that includes meaningful drug coverage.

Cost Containment

We recognize that strong and effective cost containment measures are a necessary part of a Medicare prescription drug benefit. In order for a drug benefit to be sustainable over the long run, mechanisms must be in place to control the rising costs of prescription drugs. AARP actively supports solid cost containment methods as long as patient safety and well-being is not compromised and access to prescription drugs is not impeded. We also support the responsible promotion of generic drugs as one effective cost containment tool.

Both the government and the consumer have an important role to play in helping to control costs. Therefore, in early spring, AARP will roll out a national campaign to educate our members and the public at large about the wise use of medications – including generic drugs. We will encourage our members to talk with their doctors and pharmacists and to learn as much as they can about the safe use of medications.

Conclusion

Our members believe that Congress should be able to work across party lines to enact and begin to implement an affordable Medicare drug benefit. We understand the challenges you face in crafting a proposal for a responsible Medicare drug benefit. We pledge to you that we will provide assistance in every way we can to work with members on both sides of the aisle and to promote a meaningful and broadly supported Medicare prescription drug benefit. We also know that our members will not accept failure or delay. The needs of older and disabled Americans who lack adequate drug coverage can no longer go unheeded. Now is the time to act.